A Survey of Health Care in Large. Urban Jails

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Inmate medical services present one of the most critical areas of concern for jail administrators today. Recent 42 U.S.C. 1983 decisions suggest an ominous liability fate for those who do not properly plan and execute a comprehensive health care policy. Further, massive institutional overcrowding coupled with an ever increasing drug-addicted population tend to exacerbate the problems of many systems that are designed to provide only the most rudimentary level of service.

Background

Harris County (Houston), Texas has embarked on a sweeping program to upgrade health care for inmates in the county jail. Changes include the acquisition of some fifty-five additional professionals and a complete administrative reorganization. Because few agencies have ever had to deal systematically with comparable medical programs in a jail environment, we decided to survey some of the nation's largest jails in an effort to obtain information on specific approaches and techniques that have proven successful in similar institutions.

It should be noted emphatically that this survey was not intended to compare the quality of health care services among jails. Different programs are organized to reflect unique philosophies, varying state laws concerning both jail operations and medical regulations, and institutional guidelines that have evolved for specific departments. The survey was designed to gamer a general description of health care systems at large jails throughout the country.

This review of the results is not a scientific study. Conceptually, each system is organized differently to accomplish different goals through different means. Therefore, mathematical inference is simply not applicable; no statistical treatment is presented. Again, we emphasize that the sole purpose of the survey was to provide a general description of services at large jails.

Method

We developed a fourteen-question survey to address basic service and organizational issues, including inmate population and its relationship to employee numbers by professional designation, scope of service provided, triage of patient complaints, AIDS-related issues, program costs, certification status, and other concerns. The survey was designed in an open-ended format to encourage responses when "forced choice" entries were not applicable.

The survey was sent to administrators of sixteen randomly-selected institutions outside Texas that house over 1,000 inmates, and to five administrators representing jails within Texas with a population of over 1,000. Texas was emphasized because many cultural factors affecting these jails would also apply in Harris County, and because the same state laws govern all these institutions.

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After the surveys were returned, the medical administrator of the Harris

County Jail contacted respondents by telephone to discuss the issues in greater depth.

Findings

A total of fourteen administrators, or 67 percent, responded to the survey. This represents an excellent rate of response, especially when one considers the lengthy narrative which many of the respondents chose to compose. Since responses varied widely, no mean values are reported. Rather, we chose to consider groupings of similar values by range, since a single entry could greatly skew the mean. Likewise, median and modal values assume a commonality in subject, which may not necessarily be valid in the present case.

System Organization

Ten of the fourteen jails surveyed, or 71 percent, reported that inmates are housed in multiple facilities. Generally, comprehensive health care is provided at a single location. Inmates who require more than routine nursing and physician rounds are transported to the main medical unit.

Inmate populations in the surveyed jails range from a low of 1,000 to a high of 7,000.

Inmate Population	Agencies Responding
1,000 - 2,000	6
2,000-3,000	1
3,000-4,000	1
4,000 - 5,000	2
5,000 or more	4

Staffing Trends

The results of the survey were tabulated and transposed to reflect the number of inmates served by a single staff member. See Table 1 on page 7 of this issue for a presentation of these figures. Results are summarized as follows.

- **Physician coverage** - Results indicate a wide variance in the number of on-site physicians, from a low of one physician for every 2,700 inmates to a high of one for every 125 inmates. Six of the fourteen institutions retain one physician for every 800 or fewer inmates, while six others have one for every 801-1,500 inmates. Only two reported fewer than one physician for every 1,500 inmates.

  Administrators pointed out that, in all cases, prisoners have access to comprehensive medical services through various arrangements with outside hospitals. Therefore, any analysis of on-site care must be reviewed in the full context of the availability of additional health care.

- **Registered Nurse/Physician's Assistant coverage -** Coverage by professional-level registered nurses (RNs) or physician's assistants (PAs) also varies greatly from jail to jail. Only thirteen surveys were analyzed in this category because a unique staffing pattern in one institution did not lend itself to "straight line" comparison. Of those surveys analyzed, the lowest ratio reported was one RN/PA for every 500 inmates. The highest ratio reported was one for every fifty-two inmates. Seven facilities reported one RN/PA for every 125 or fewer inmates. Four reported one RN/PA for every 126 to 250 inmates, and three reported one for more than 250 inmates.

- **Licensed Visiting Nurse/ Licensed Practical Nurse coverage-** Thirteen of the fourteen respondents reported utilizing licensed visiting nurses (LVNs) or licenced practical nurses (LPNs). Responses in this category indicated less variation. With the exception of one institution, which is staffed at one LVN/LPN for every sixty inmates, all staffing reflects one LVN/LPN for every 100 - 250 inmates.

- **Psychiatrist/Psychologist coverage** - The number of full-time psychiatrists and psychologists varies greatly among institutions. The highest ratio reported was one psychiatrist/psychologist for every 106 inmates. The lowest ratio reported was one for every 3,000

inmates. Ten of the fourteen jails reported one psychiatrist or psychologist for every 1,000 or fewer inmates, while four reported one for 1,000 or more inmates.

- **Dentist coverage** -Institutions vary greatly in the number of dental staff they provide. Responses range from a high of one dentist for every 550 inmates to a low of one for every 5,500 inmates.
- **Ancillary service staff** - Respondents reported wide variations in staffing of support services, such as pharmacy, labs, and radiology. Further, numbers of administrative staff, clerical employees, and records technicians vary greatly among jails. Only two jails reported on-site optometry services.

Scope of Services

Six survey questions dealt with the scope of services provided onsite. Respondents often noted that inmates receive some of the services discussed below through prior arrangement with public or private hospitals. Therefore, a negative response to a question on the survey should not be construed as indicating that the service is not available.

Two of the fourteen administrators indicated that they do not contract for any services. However, telephone follow-up revealed that both of these institutions rely on a local public health authority for many services, although no formal contractual relationship exists. When the results are adjusted for these semantic interpretations, it appears that nine of the fourteen departments provide limited services through the sheriff's department or equivalent with public health agencies. Organizational models are uniquely tailored to each agency.

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Availability of Non-Emergency Services

- **Physician care - Only** one agency indicated that physicians are actually on-site around the clock, seven days per week. A second agency reported that physicians are on-site around the clock, five days per week, plus sixteen hours per day on weekends. A third agency reported physicians on-site an average of fourteen hours per day. Seven agencies reported coverage from fifty to seventy hours per week. Three agencies reported coverage for fewer than seven hours per day. The remaining institution reported a variable rate among autonomous facilities.
- **Dental care** - Five respondents reported providing the equivalent of one full-time dentist (eight hours per day, five days per week), while three reported ten- to fourteen-hour daily coverage or several dentists working concurrently. Five departments responded that dentists are available from two to six hours daily. One agency did not respond.

  When asked the type of dental services provided, six administrators indicated "emergency only"; two replied "restorative only"; one indicated that both preventative and emergency services are provided; and five indicated that preventative, restorative and emergency services are provided.

- **Optometry** - Two departments reported that optometrists are on site, one for three hours per week and the other for four hours per week.
- **Pharmacy** - Seven agencies reported on-site pharmacies, while six reported no on-site pharmacy. One agency did not respond to the question.
- **Radiology** - Seven agencies reported on-site radiology from four to eighty hours per week. Six reported no on-site radiology,

while the last respondent did not submit a specific answer.

- **Intake screening** - All respondents reported that incoming inmates are medically screened. Thirteen of fourteen respondents indicated screening is a twenty-four-hour operation.
- **AIDS counseling/screening** - All fourteen agencies reported that some form of AIDS counseling and screening is available.

Triage of Medical Complaints

One of the most critical issues facing administrators of the Harris County Jail is the triage of inmate medical needs in a timely and orderly manner. The survey asked each respondent the type of program used to respond to medical complaints.

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Eleven of the fourteen administrators noted that medical triage is performed at both medical clinics and inmate living areas. Three responded that triage is normally performed in the clinic. A degree of variation was reported on the licensure of triage personnel. Four reported that MDs are present, along with some combination of RNs and/or PAS. Two reported that triage is performed exclusively by RNs. Seven responses were unclear as to whether RNs, PAS, LVNs or other medical staff have primary responsibility.

Program Costs

This issue produced a wide variety of responses. Five of the fourteen did not respond at all, while a sixth did not include personnel costs. There seems to be a huge disparity in the ways agencies calculate the costs of public health contributions as they relate to jail programs. Further, the formulas for estimating in-kind matching and security-associated costs are treated differently.

With these limitations in mind, consider the following survey responses: Two organizations reported total medical services costs of less than $1,000 per inmate per year. The lowest was $500 per inmate per year, and the second lowest was $625 per inmate per year. Four respondents reported costs between $1,000 and $1,500 per inmate per year. One reported a cost of $1,683 per inmate per year. The highest figure reported was $2,666 per inmate per year.

Certification by the National Commission on Correctional Health Care (NCCHC)

Of the fourteen agencies responding to the survey, only three have been certified by the NCCHC. Two other agencies reported that they are seeking certification, and several reported certification by state or national, non-medical organizations.

Respondents Cite Most Crucial Issues

The survey also posed an open-ended question which asked the administrators to list those issues they deemed the most crucial. Thirteen of the fourteen respondents completed the question. Crucial issues mentioned by the administrators were as follows:

Issues Cited	Number of Respondents
HIV and AIDS	8
Rising health care costs	6
Overcrowding	6
Shortage of professional staff	4
Mental health issues	3

Conclusions

Due to the lack of precise scientific design in this survey, we initially questioned the advisability of drawing firm conclusions. However, the data obtained from the survey and information gathered in follow-up conversations led us to sense a feeling of commonality among administrators. Even though we cannot report “findings” per se, we can outline “trends” that seem to characterize health services in urban jails. These are presented for the

reader and should be judged against his/her own environment.

- **High interest** - High interest was evidenced by the response rate, as well as by the letters and comments attached. All responses were freely provided. A sense of urgency accompanied the dialogue which ensued; most of the personnel surveyed expressed a desire to continue some form of information-sharing. We therefore conclude that both formal and informal means should be used to bring together professionals in large jail health care to share experiences.
- **Diversity of organizational structure** - Each jail studied has its own distinct organization. All utilize the resources of the sheriff's department in conjunction, in varying degrees, with a local public health authority. Multiple facility programs, the most common model in urban centers, are characterized by even more individualized operations. Local philosophies, laws, customs, length of inmate stay, tax base, and other factors drive the system and generally determine the policies and methods of providing health care.

This diversity of organization precludes the notion of some mystical model being acclaimed as the "best" system in the country. Health care must be tailored to meet local needs in the context of existing local agencies. This is not to suggest, of course, that systems cannot incorporate certain elements from other programs. They can; however, each must, above all, serve the local system effectively and efficiently.

- **Budgetary confusion** - A clearly defined budgeting process for health care is lacking in most large jails. Respondents expressed a real need to establish mechanisms by which all costs related to health care are identified and appropriately budgeted. Some respondents were unable to provide data in this area, and others were unable to determine shared costs within the jail. This phenomenon can be explained by the fact that, without exception, jail health care is a function of at least two separate agencies, often operating from separate tax bases.

Medical issues frequently are foreign to the jail administrator; conversely, security issues often are foreign to the hospital administrator. Some agencies seem to have bridged this gap with success, but others have not. Our study encountered systems which spend tens of millions of dollars annually on jail health care. Expenditures of this magnitude demand rigid accountability.

- **Crucial issues** - Perhaps the most striking information gained from the survey is what issues administrators consider the most critical. Again, these are:

1. AIDS.
2. Rising health care costs.
3. Jail overcrowding.
4. A shortage of medical professionals.
5. The need for expanded mental health services.

Both formal and informal means should be used to bring together professionals in large jail health care to share experiences.

Recommendations

Based on the limited conclusions detailed above, we recommend that jail administrators consider inmate health care a priority issue. Large jails must continue to develop new and innovative partnerships with local health authorities, as well as with private sector health care organizations and medical schools. On-site clinics, labs, and support services seem appropriate when volume justifies the expenditure. Strict budgetary guidelines need to be implemented. Finally, we recommend that NIC assume an active role in fostering information dissemination among large jail health care systems.

Table I
Staffing Trends: Number of Inmates Served by Each Full-Time, On-Site Staff Member

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10	Case 11	Case 12	Case 13	Case 14
Administration	800	-	750	500	1,100	1,500	500	750	5,500	-	1,500	1,000	51	1,000
Medical Records	200	-	250	-	423	300	267	-	5,500	1,000	1,500	-	-	1,165
Clerical	1,333	625	750	750	400	-	2,000	750	5,500	1,000	1,500	1,000	5,000	1,400
Soc/Ed	1,333	-	300	250	900	375	1,000	-	-	500	1,000	-	-	583
Pharmacy	4,000	-	1,500	-	1,375	2,000	1,333	-	-	-	3,000	-	775	1,000
Technician	4,000	-	-	-	611	6,000	4,000	1,500	-	-	1,500	-	200	1,167
Physician	210	1,100	750	750	500	1,200	285	1,500	2,700	1,000	2,000	1,000	125	875
Dentist	1,333	2,500	1,500	1,500	785	1,500	4,000	1,500	5,500	1,000	3,000	1,000	550	3,500
Psychiatrist/ Psychologist	750	2,500	750	750	366	1,500	666	500	1,833	1,000	3,000	1,000	106	1,000
R.N./Physician's Assistant	71	313	150	125	229	52	68	100	-	111	300	500	88	350
L.V.N./L.P.N.	160	192	60	125	204	250	133	167	125	-	200	100	312	140
Other	800	-	-	-	487	300	-	-	1,000	-	-	-	-	260

This table was compiled using results of the authors' survey of health systems in large jails. For more information, contact Mark Kellar or Lanny Chopin at the Harris County, Texas, Sheriff's Department, Houston, Texas; telephone (713) 221-7223. ■